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Volume VII

**Assessing Health
Sector Policy
Reform Strategies in
Egypt: A Summary
of PHR Analyses**

August 1997

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Partnerships
for Health
Reform

PHR



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Partnerships
for Health
Reform

Mission

The Partnerships for Health Reform Project (PHR) seeks to improve people's health in low- and middle-income countries by supporting health sector reforms that ensure equitable access to efficient, sustainable, quality health care services. In partnership with local stakeholders, PHR promotes an integrated approach to health reform and builds capacity in the following key areas:

- ▲ *policy formulation and implementation*
- ▲ *health economics and financing*
- ▲ *organization and management of health systems*

PHR advances knowledge and methodologies to develop, implement, and monitor health reforms and their impact, and informs and guides the exchange of knowledge on critical health reform issues.

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Abstract

In response to a request from the Health Office of the United States Agency for International Development/Cairo, the Partnerships for Health Reform (PHR) Project conducted six analyses between June and September 1996 to support and inform the design of the Mission's upcoming Health Sector Reform Program Assistance. This Sector Program Assistance is intended to provide technical and financial assistance to the government of Egypt in planning and implementing a series of health policy reforms aimed at improving the financing, efficiency, access, and quality of health services in Egypt. PHR's six analyses were designed to answer two questions about the set of health sector reform strategies that were proposed jointly by the Ministry of Health and Population and the United States Agency for International Development:

- ▲ Are these reforms feasible?
- ▲ What will be the impact of these reforms?

The analyses summarized in this report are addressed in detail in PHR Technical Report No. 5 in six volumes, listed below by volume number.

Volume I	Suggested National Health Sector Reform Strategies, Benchmarks, and Indicators for Egypt (James C. Setzer)
Volume II	Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt (James Knowles and David Hotchkiss)
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Volume VII	Summary of Analyses

Findings of the six analyses suggest that the United States Agency for International Development's and the Ministry of Health and Population's health policy reform strategies aimed at improving the financing, efficiency, access, and quality of health services in Egypt comprise an ambitious yet feasible reform agenda. The reports attempt to estimate the impact of the reforms on

the health sector, and several offer specific suggestions to refine reform strategies in order to achieve the best results.

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Acronyms

CCO	Curative Care Organization
CAPMAS	Central Agency for Public Mobilization and Statistics
CME	Continuing Medical Education
CRHP	Cost Recovery for Health Project
DDM	Data for Decision Making Project
DHS	Demographic and Health Survey
GDP	Gross Domestic Product
GIS	Geographic Information Systems
GNP	Gross National Product
GOE	Government of Egypt
HIO	Health Insurance Organization
HIS	Health Information System
IDSC	Information and Decision Support Center
MCH	Maternal and Child Health
MOHP	Ministry of Health and Population
MOU	Memorandum of Understanding
NGO	Non-governmental Organization
NPA	Non-Program Assistance
PHC	Primary Health Care
PHR	Partnerships for Health Reform
PM	Preventive Medicine
SPA	Sector Program Assistance
USAID	United States Agency for International Development

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Executive Summary

In response to a request from the Health Office of the United States Agency for International Development/Cairo, the Partnerships for Health Reform (PHR) Project conducted six analyses between June and September 1996 to support and inform the design of the Mission's upcoming Health Sector Policy Reform Program Assistance. This Sector Program Assistance is intended to provide technical and financial assistance to the government of Egypt in planning and implementing a series of health policy reforms aimed at improving the financing, efficiency, access, and quality of health services in Egypt. PHR's six analyses were designed to answer two questions about the set of health sector reform strategies that were proposed jointly by the Ministry of Health and Population and the United States Agency for International Development:

- ▲ Are these reforms feasible?
- ▲ What will be the impact of these reforms?

The analyses summarized in this report are addressed in detail in PHR Technical Report No. 5 in six volumes, listed below by volume number.

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Volume VII	Summary of Analyses

This summary report is comprised of sections that correspond to the separate volumes of this technical report and describe each study or analysis and its findings in detail. Each section summarizes the purpose of the analysis or study and key findings and recommendations regarding the feasibility and possible impact of the reform strategies. Two tables summarize the specific reform

strategies agreed upon by the Ministry of Health and Population and the United States Agency for International Development and suggest indicators that were defined for each reform strategy.

Findings of the six analyses suggest that the United States Agency for International Development/Ministry of Health and Population health policy reform strategies aimed at improving the financing, efficiency, access, and quality of health services in Egypt comprise an ambitious yet feasible reform agenda. The reports attempt to estimate the impact of the reforms on the health sector and several offer specific suggestions to refine reform strategies in order to achieve the best results. Specific findings of each analysis are included below.

- ▲ The economic analysis indicates that the government of Egypt should use the reform agenda and Sector Program Assistance (SPA) as opportunities to reduce inefficiencies in the health sector and to reap the substantial economic benefits and gains in efficiency that will accompany the reforms if they are implemented properly.
- ▲ The overall conclusion of the social vulnerability analysis is that most aspects of the policy reform agenda will have positive effects on socially vulnerable populations. In the case of cost recovery, however, the impact on the socially vulnerable will depend on how the cost recovery scheme is implemented. If suitable mechanisms for identifying and exempting the poor from having to pay user fees (e.g., means testing, geographic targeting) are developed, implemented, and carefully evaluated, the potentially adverse effects of user fees on vulnerable populations can be minimized.
- ▲ The legal analysis concludes that although there are no absolute legal constraints to the proposed policy reforms, there may be a need for issuance of presidential and ministerial decrees or amendments to existing laws in order to effectively implement some of the activities.
- ▲ The analysis of Egypt's political environment for health policy reform indicates that both opportunities and obstacles exist. Although the government is likely to continue to avoid controversial policies or hard decisions that are likely to provoke public resistance or political antagonism, there is room to move forward with health sector reforms and policy changes deemed "politically safe" that can improve the overall performance of the health sector, alleviate its current distortions and inequities, and prepare the groundwork for more aggressive structural changes.
- ▲ Analysis of the institutional capacity of Egypt's health care providers concludes that, although there are institutional problems confronting Egyptian health care organizations, the future of reform appears positive and its implementation should be encouraged. In fact, the diversity and intensity of the existing problems are ideal for a sector-level approach to reform. In addition, a reform will likely redefine the roles of health sector organizations, and this redefinition may, in itself, solve many of the institutional deficiencies, with little need for further intervention.

1. Introduction

In response to a request from the Health Office of the United States Agency for International Development (USAID)/Cairo, the Partnerships for Health Reform (PHR) Project conducted six analyses between June and September 1996 in order to support and inform the design of the Mission's upcoming Health Sector Policy Reform Program Assistance. This Sector Program Assistance (SPA) is intended to provide technical and financial assistance to the government of Egypt (GOE) in planning and implementing a series of health policy reforms aimed at improving the financing, efficiency, access, and quality of health services in Egypt. The SPA will provide technical assistance on designing and implementing the reforms, as well as financial assistance that is intended to offset the short-term costs associated with those reforms. SPA funds will be provided to the government in "tranches," and are conditional on the GOE reaching agreed-upon benchmarks that measure progress toward achieving the reforms.¹ PHR's six analyses were designed to answer two questions about the set of health sector reform strategies (see Table 1) that were proposed jointly by the Ministry of Health and Population (MOHP) and USAID:

- ▲ Are these reforms feasible?
- ▲ What will be the impact of these reforms?

PHR sectoral analyses were designed to assess the feasibility and impact of each reform strategy within several contexts. In addition to the development of suggested indicators and benchmarks to track health policy reform, PHR analyses included: an economic analysis of the reforms, including cost-effectiveness and benefit-cost analyses; a social vulnerability analysis to determine the impact of suggested health sector reforms on poor women and children and other "socially vulnerable" groups; a legal analysis to determine the feasibility of the suggested reforms and legal actions required to enact them; a political analysis to examine the political feasibility of enacting the reforms and the actions required to implement them; and, an institutional analysis to examine the capabilities of the major players in the health sector to adequately prepare for and implement the reforms.

1.1 A Summary of PHR Sectoral Analyses

The analyses summarized in this report are addressed in detail in PHR Technical Report No. 5 in six volumes, listed below by volume number.

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¹SPA was formerly referred to as "Non-Project Assistance" (NPA).

Volume II	Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt (James Knowles and David Hotchkiss)
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This summary report is comprised of sections that correspond to the separate volumes of this technical report and describe each study or analysis and its findings in detail. Each section summarizes the purpose of the analysis or study and key findings and recommendations regarding the feasibility and possible impact of the reform strategies. Two tables summarize the specific reform strategies agreed upon by the MOHP and USAID and suggest indicators that were defined for each reform strategy.

1.2 Egypt's Proposed Reform Agenda

The proposed reform agenda focuses on redefining the role of the MOHP and reforming the National Health Insurance Program. The reforms fall into six main categories as follows:

- ▲ Rationalizing the role of the MOHP in financing curative care by decreasing the proportion of the government's budget going to curative care and increasing the resources available for preventive and primary health care (PHC). These strategies include: stopping the construction of unnecessary hospitals, transferring existing MOHP hospitals to other parastatal organizations (such as the Health Insurance Organization [HIO]), encouraging hospital autonomy, and expanding cost recovery in government hospitals, as well as introducing cost recovery for curative outpatient care in PHC clinics on a pilot basis.
- ▲ Strengthening the role of the MOHP in providing and financing PHC, which includes conducting cost-effectiveness analyses to identify a package of essential health services, increasing resources to maternal and child health (MCH) programs, and providing incentives to health care professionals to specialize in PHC and family medicine.

- ▲ Reforming the MOHP personnel policy, including ending guaranteed employment for all medical school graduates, reducing the overall number of personnel, redistributing personnel based on needs, and providing incentives to MOHP personnel to practice in underserved and remote areas.
- ▲ Developing the MOHP capacity for national health needs assessment, sectoral strategic planning, and policy development. This includes upgrading the national health information system to allow for improved planning and policy decision making and prioritizing allocation of MOHP resources based on needs using health status indicators.
- ▲ Developing the MOHP role in regulation; accreditation; quality assurance, including developing national health standards of practice and health facility accreditation; and establishing policies of licensing and continued medical education for physicians.
- ▲ Ensuring the viability of the HIO, transforming it into a purely financing organization, and expanding social health insurance coverage in the long run.

Table 1 provides the complete list of the health sector policy reforms jointly proposed by the USAID and the MOHP.

Table 1: Egypt's Proposed Health Sector Policy Reforms

1. ROLE OF THE MINISTRY OF HEALTH AND POPULATION (MOHP)			
1.1. Rationalize the Role of the MOHP in Financing Curative Care			
1.1.1	Stop the construction of unnecessary hospitals and set strict guidelines for the completion of facilities under construction	1.1.5	Allow hospital autonomy
1.1.2	Transfer existing hospitals to other parastatal organizations	1.1.6	Support hospitals based on efficiency indicators such as on a per capita, per bed basis, etc.
1.1.3	Expand cost recovery in government facilities	1.1.7	Examine the cost recovery of curative services at the PHC level
1.1.4	Allow private practitioners to use the MOHP facilities		
1.2 Strengthen the role of the MOHP in the provision and increased share of financing preventive medicine (PM) and primary health care (PHC)			
1.2.1	Use cost effectiveness analysis to identify a package of PM and PHC services to be supported by MOHP to which every Egyptian is entitled	1.2.4	Do not separate curative services at the PHC level
1.2.2	Increase emphasis on Maternal and Child Health Care programs	1.2.5	Ensure adequate allocation of resources, e.g., personnel
1.2.3	Provide incentives for the health care providers to specialize in PM, PHC, and family medicine		
1.3 Reform the MOHP personnel policy			
1.3.1	Eliminate guaranteed employment	1.3.3	Reduce the overall number of MOHP personnel
1.3.2	Develop guidelines for MOHP personnel and apply them to redistribute personnel based on needs assessment	1.3.4	Provide incentives for the MOHP personnel to serve in under served and remote areas
1.4 Develop the MOHP capacity for national health needs assessment, sectoral strategic planning, and policy development			
1.4.1	Adapt the national health information systems for planning and policy decision making	1.4.4	Target government of Egypt subsidy to poor and indigent populations
1.4.2	Prioritize the allocation of MOHP resources based on needs using health status indicators	1.4.5	Use cost-effectiveness analyses in determining the essential health services
1.4.3	Create incentives for other health care providers to function in under served areas		
1.5 Develop the MOHP role in regulation, accreditation, and quality assurance of health services			
1.5.1	Develop and adopt National Health Standards of Practice and health facility accreditation	1.5.2	Establish a policy of continued physician licensing and continuing medical education

2. NATIONAL SOCIAL HEALTH INSURANCE PROGRAM

2.1 Ensure the viability of the Health Insurance Organization (HIO)

2.1.1	Do not add any new groups of beneficiaries to HIO	2.1.5	Change the HIO legal and legislative framework to ensure its autonomy
2.1.2	Eliminate the current HIO deficit	2.1.6	Develop premiums based on actual costs using co-payments and deductibles
2.1.3	Reduce the proportion of the pharmaceutical costs	2.1.7	Identify and adopt affordable health benefit package(s)
2.1.4	Unify the existing health insurance laws into one law		

2.2 Transform the HIO into a financing organization

2.2.1	Stop constructing new HIO hospitals	2.2.3	Develop different mechanisms to subcontract all health service providers, including private and MOHP hospitals
2.2.2	Develop a plan to sell or transfer to other private or parastatal organizations, in phases, the existing HIO hospitals, polyclinics, and general practitioner clinics	2.2.4	Allow beneficiaries to choose service providers

2.3 Expand social health insurance coverage coupled with adequate administrative and financing mechanisms

2.3.1	Design and develop a single national health insurance fund for universal coverage	2.3.3	Separate financing from provision of services
2.3.2	Develop a well-defined standard package of benefits that every citizen is entitled to receive	2.3.4	Ensure legal and financial autonomy of fund

1.3 New Partnerships in the Health Sector

The proposed reforms attempt to define a vision for the shape of Egypt's health sector as well as a path through which health services delivery and financing becomes a much broader and richer partnership that involves not only the MOHP, but also private and social insurance institutions, and private and parastatal health care providers. In general, the reforms propose to shift the role of the MOHP and HIO away from direct service provision toward a role of financier and regulator. The new partnership that is implied within the proposed reform agenda can be characterized by:

- ▲ An MOHP that is responsible for the delivery of preventive and primary care services but that finances a package of secondary and tertiary services delivered by either private or parastatal health care delivery institutions.
- ▲ An expanded role for the Curative Care Organizations (CCOs) in the management of all secondary and tertiary care facilities currently operated by the MOHP.
- ▲ An HIO that is no longer involved in the direct provision of services but acts as a single national health insurance fund with universal coverage.

1.4 Summary of the Major Findings of the Analyses

The six analyses summarized here suggest that the USAID/MOHP health policy reform strategies aimed at improving the financing, efficiency, access, and quality of health services in Egypt comprise an ambitious yet feasible reform agenda. The reports analyze the feasibility as well as the impact of the reforms on the health sector and several offer specific suggestions to refine reform strategies to achieve the best results.

- ▲ The economic analysis indicates that the GOE should use the reform agenda and SPA as opportunities to reduce inefficiencies in the health sector and to reap the substantial economic benefits and gains in efficiency that will accompany the reforms, if they are implemented properly.
- ▲ The overall conclusion of the social vulnerability analysis is that most aspects of the policy reform agenda will have unambiguously positive effects on the socially vulnerable. In the case of cost recovery, however, the impact on this population will depend on how the cost recovery scheme is implemented. If suitable mechanisms for identifying and exempting the poor from having to pay user fees (e.g., means testing, geographic targeting) are developed, implemented, and carefully evaluated, the potentially adverse effects of user fees on vulnerable populations can be minimized.
- ▲ The legal analysis concludes that although there are no absolute legal constraints to the proposed policy reforms, there may be a need for issuance of presidential and ministerial decrees or amendments to existing laws in order to effectively implement some of the reforms.
- ▲ The analysis of Egypt's political environment for health policy reform indicates that both opportunities and obstacles exist. Although the GOE is likely to continue to avoid controversial policies or hard decisions that are likely to provoke public resistance or political antagonism, there is room to move forward with health sector reforms and policy changes deemed "politically safe" that can improve the overall performance of the health sector, alleviate its current distortions and inequities, and prepare the groundwork for more aggressive structural changes.
- ▲ The analysis of institutional capacity of Egypt's health care providers concludes that, although there are tremendous institutional problems confronting Egyptian health care organizations, the future of reform appears positive and its implementation should be encouraged. In fact, the diversity and intensity of the existing problems are ideal for a sector-level approach to reform. In addition, the reforms will likely redefine the roles of health sector organizations, and this redefinition may, in itself, solve many of the institutional deficiencies, with little need for further intervention.

Along with a summary of the report on suggested benchmarks and indicators, the major findings of each of the five analyses are further summarized in the following sections.

2. Suggested Benchmarks and Indicators for National Health Sector Reform Strategies

Volume I of the series of analyses, *Suggested National Health Sector Reform Strategies, Benchmarks, and Indicators for Egypt* (James C. Setzer), proposes appropriate verifiable benchmarks and suggested indicators to be used by USAID and the MOHP to track MOHP progress toward the completion of the health sector reform agenda. For each reform strategy related to the roles of the MOHP and the HIO, assumptions about the Egyptian context are given followed by suggested benchmarks (for Year One and Years Two to Five) and indicators. Data sources and baseline values for each indicator are also provided in the report.

The health sector reform agenda contains a mixture of legal and legislative changes, government policy reforms, and administrative and management procedural changes. It is anticipated that a subset of these reforms will form the basis of the Sector Program Assistance (SPA) agreement between USAID and the GOE. The benchmarks in this report were developed to track MOHP progress toward the completion of the mutually agreed-upon health sector reform agenda and will be included in the program agreement as conditions precedent to the release of program funds. Program funds are intended primarily to assist the MOHP and GOE to meet (or offset) short-term costs associated with the reforms.

Because the reform agenda seeks to influence policy and operations in a wide range of areas, suggested benchmarks and indicators contained in this document may be useful to the Mission in further refining and focusing the reforms for inclusion into the final SPA strategy. It should also be remembered that the reform agenda supported by the SPA alone will be insufficient to bring about a sector-wide transformation. The elements of the USAID-supported agenda should be developed in concert with other donors that are actively involved in health sector reform, particularly the World Bank.

Table 2 lists suggested indicators along with the health reform strategy(ies) identified in Table 1 that they are attempting to measure. Following Table 2, Figure 1 illustrates an example of assumptions, benchmarks, and indicators suggested for a specific health sector reform strategy related to ensuring equity in health care for vulnerable populations.

Table 2: Suggested Indicators, Strategies, Definitions, Data Sources, and Baseline Values

INDICATOR	STRATEGY(IES)	DEFINITION	DATA SOURCES	BASELINE VALUE
Percent of MOHP funding allocated to primary and preventive services	1.1.1, 1.1.2, 1.1.3, 1.1.4, 1.1.5, 1.1.6, 1.1.7, 1.2.1, 1.2.2, 1.2.3, 1.2.5, 1.3.3, 1.4.2, 1.4.4, 1.4.5	Funds allocated to primary and preventive services as a percent of total MOHP recurrent budget	MOHP budget tracking system	40% (1994)
Policy measures and benchmarks established and agreed to with MOHP	1.1.1, 1.1.2, 1.1.5, 1.1.6, 1.1.7, 1.2.1, 1.2.5, 1.3.1, 1.3.2, 1.3.3, 1.3.4, 1.4.3, 1.4.4, 1.4.5, 1.5.1, 1.5.2	Yes or no	Joint MOHP - USAID Memorandum of Understanding (MOU)	no (1995)
Number of MOHP hospitals/polyclinics/ primary care facilities operating as cost recovery facilities	1.1.3, 1.1.4, 1.1.5, 1.1.7, 1.4.4	Number of facilities implementing cost recovery model as a percent of total number of facilities of each level	MOHP budget tracking system	0 (1995)
Social insurance	2.1.1, 2.1.2, 2.1.3, 2.1.4, 2.1.5, 2.1.6, 2.1.7, 2.3.1, 2.3.2, 2.3.4	Percent of Egyptians covered under social insurance	HIO beneficiary registration reports	30% (1994)
Quality assurance committees		Number of hospitals with functioning Quality Assurance committees and submitting regular reports	MOHP management reports	1 (1995)
Facilities submitting required reports and data	1.4.1	Number of governorates with operational MIS and submitting required reports and data	MOHP management reports; MOHP MIS reports	0 (1994)
Inpatient care provided in private and parastatal facilities	1.1.2, 1.1.4	Number of inpatient bed days provided in private and parastatal facilities as a percent of total inpatient bed days	MOHP management reports	10% (1991)
Percent of governorates meeting (but not exceeding by >10%) population-based targets for numbers of health facilities at all levels	1.1.1	Number of governorates who meet population-based targets for numbers of facilities of all levels	MOHP management reports	Targets not available
Percent of hospitals remaining under direct MOHP management	1.1.2	Number of MOHP managed hospitals as percent of all hospital facilities	MOHP management reports	64.1 (1995)

INDICATOR	STRATEGY(IES)	DEFINITION	DATA SOURCES	BASELINE VALUE
Percent of governorates with functioning CHOs	1.1.2	Number of governorates with functioning CHOs as percent of total governorates (27)	MOHP management reports	19.2 (1992)
Cost recovery revenues as a percent of total MOHP non-personnel recurrent budget	1.1.3, 1.1.4, 1.1.7	Total cost recovery revenues at MOHP facilities as a percent of total MOHP non-personnel recurrent budget	MOHP budget tracking system	1.3 (1992)
Percent of hospitals allowing private practitioner user of facilities	1.1.4	Number of hospitals allowing private practitioners to use facilities as percent of all hospitals	MOHP management reports	Data not currently collected
Average length of hospital stay	1.1.6	Average length of stay for all hospital inpatients	Facility records and reports	4.8 (1991)
Occupancy rate for MOHP hospital beds	1.1.6	Number of bed days occupied as percent of total bed days	Facility records and reports	49 (1991)
Inpatient mortality rate	1.1.6, 1.5.1, 1.5.2	Mortality rate for inpatients in MOHP hospitals	Facility records and reports	1.1 (1991)
Percent of MOHP recurrent budget allocated to support chosen cost-effective package	1.2.1	Budget resources allocated to adopted package as a percent of total recurrent budget	MOHP budget tracking system	Package not identified
Rates of incidence and prevalence of diseases targeted by chosen cost effective package	1.2.1	Number of new case per population for time period	MOHP Health Information System (HIS)	Data available - diseases not identified
Coverage rates and service delivery statistics for priority MCH programs identified	1.2.2, 1.2.3, 1.4.2, 1.4.5	Number of services delivered per target population	MOHP HIS	Data available - MCH programs not identified
Incidence rates for childhood preventable diseases	1.2.2, 1.2.3, 1.4.5	Number of new cases per population for time period	MOHP HIS	Data available
Maternal mortality rate	1.2.2, 1.2.3, 1.4.5	Number of maternal deaths per 100,000 deaths	MOHP HIS	194 (1990)
Infant mortality rate	1.2.2, 1.2.3, 1.4.5	Deaths age 0-1 year per 1,000 live births	MOHP HIS	33 (1989)
Coverage with targeted specialties	1.2.3	Number of specialists in identified specialties per 100,000 population	MOHP management reports	Data available - indicator not calculated

INDICATOR	STRATEGY(IES)	DEFINITION	DATA SOURCES	BASELINE VALUE
Percent of MOHP recurrent budget allocated to PHC facilities	1.2.4	Total recurrent budget allocation to PHC facilities as percent of total MOHP recurrent budget	MOHP budget tracking system	Data available - indicator not calculated
Percent of MOHP primary level facilities staffed and equipped according to established norms	1.2.5, 1.3.2, 1.3.4	Number of facilities staffed or equipped according to norms as percent of total primary facilities	MOHP management reports	Norms not established
MOHP personnel costs as percent of total MOHP recurrent budget	1.3.1, 1.3.3	Total MOHP wage costs as percent of total MOHP recurrent budget	MOHP budget tracking system	70.4 (1993)
Percent of patients receiving exemptions, waivers, or reduced fees	1.4.4	Number of patients receiving exemptions, waivers, or reduced fees as percent of total number of patients	Facility management reports	Data not currently available
Number of Continuing Medical Education (CME) courses and participants	1.5.2	Number of CME courses given and total number of course participants	MOHP-CME management reports	CME program does not currently exist
Percent HIO surplus or deficit	2.1.2	HIO surplus or deficit as percent of total revenue	HIO management and financial reports	Data available
Percent HIO expenditures for pharmaceuticals	2.1.3	Total HIO expenditures for pharmaceuticals as percent of total HIO expenditures	HIO management and financial reports	53 (1992)
Number of HIO facilities	2.2.1, 2.2.2	Total number of facilities operated and managed by HIO	HIO management and financial reports	24 (1992)
Number and cost of services provided by contractors as percent of total services and costs	2.2.3, 2.2.4	Total number and value of services provided by contract providers as percent of total services and costs delivered directly by HIO	HIO management and financial reports	Not applicable - contracts not established

Figure 1: An Example of Suggested Benchmarks and Indicators

Reform Strategy

Target Government Subsidy to Poor and Indigent Populations

Assumptions

This reform strategy assumes that current GOE subsidies are not adequately targeted to the poor and indigent. The reasons for this lack of adequate targeting are unclear. The redistribution of resources in favor of rural populations may be one effective means to retarget subsidies based on the assumption that rural populations are poorer than urban ones. Geographic targeting may be more feasible than targeting individuals requiring subsidized services (which, pending the implementation of cost recovery measures on a much broader scale, means all public services). Another potential strategy for better targeting is instituting cost recovery with mechanisms to exempt the poor from payments. The costs of alternative targeting methods must be considered. In addition, the incidence and cost of leakage (i.e., subsidies which go to people who do not qualify for them) should be estimated for the targeting options to be considered.

Suggested Benchmarks

<i>Year One:</i>	The MOHP will submit a report to USAID analyzing options for improving the ability of the MOHP to target its subsidies towards the poor and indigent. The report will assess each option's cost. The report will also provide a plan and timeline for the adoption and implementation of one or more of the options studied.
<i>Years Two to Five:</i>	The MOHP will submit reports of its budget tracking system to USAID to document the implementation of chosen actions to improve the targeting of MOHP subsidies to the poor. The reports will monitor implementation efforts against the time line developed in year one.

Indicators

The following USAID/Cairo Strategic Objective 7 result indicators are relevant to the assessment of the strategy's ability to improve targeting of MOHP subsidies to the poor:

- ▲ Percent of MOHP funding (recurrent budget) allocated for primary and preventive services;
- ▲ Policy measures and benchmarks established and agreed to with the MOHP; and,
- ▲ Number of MOHP hospitals, polyclinics, and/or primary health care centers operating as cost recovery facilities.

The following outcome indicator is also suggested to assess the strategy's effect on MOHP subsidies:

3. Economic Analysis of the Proposed Health Reform Agenda

Volume II in the series, *Economic Analysis of the Health Sector Policy Reform Program Assistance in Egypt* (James Knowles and David Hotchkiss), analyzes the Egyptian economy's potential gains in efficiency and the net social benefits that might result from the health reform strategies proposed by the MOHP and USAID. The analysis is based on several approaches, including:

- ▲ a perspective of Egypt's macroeconomic environment as it pertains to health sector reform;
- ▲ a cost-effectiveness comparison of several health sector interventions to the policy reform;
- ▲ estimates of the cost-benefit ratio and internal rate of return for the investment represented by USAID's proposed SPA policy reform; and,
- ▲ an analysis of the benefits and costs of the individual strategies that comprise the reform agenda.

The major findings from this analysis are summarized below.

3.1 Egypt's Macroeconomic Environment

Egypt's macroeconomic environment has stabilized considerably since 1991. The rate of economic growth, however, is still sluggish. Slow economic growth, together with the discipline required by structural adjustment and failure to expand the tax base, constrain future growth in government spending, of which only about 3 percent is allocated to health services in recent years. The real exchange rate has appreciated by about 31 percent since 1991, and a devaluation may be on the horizon. Given the importance of drugs in total health sector spending (42 percent in 1990/91), a devaluation would have a strong adverse effect on both government and private health providers. Employment in Egypt is not expected to expand rapidly, if at all, in the two largest sectors (government and agriculture). The fact that the informal sector already employs an estimated 30 percent to 50 percent of the labor force is an obstacle to the further expansion of social insurance. Privatization has been progressing slowly, and substantial barriers to private sector competitiveness remain. In health care, however, the private sector is playing an increasingly important role, already accounting for more than half of all health care spending.

3.2 Cost-Effectiveness and Benefit-Cost Analyses of the Proposed Health Reforms

An analysis of World Bank data from 49 developing countries indicates that Egypt's health system is the least efficient country in the sample, with an average life expectancy at birth of almost seven years less than is predicted considering its per capita gross domestic product (GDP), education, and the percent of GDP spent on health. If Egypt were able to attain even the average level of health sector efficiency as other countries in the sample, the analysis shows that it would be able to attain the same health outcomes at a saving of \$1.7 billion. Cost-effectiveness analysis based on the regression analysis indicates that if the health policy reform SPA were able to reduce only 10 percent of the Egyptian health sector's "efficiency gap," it could produce an extra year of life at a cost of only \$1.84. In this case, the cost effectiveness of the SPA would compare quite favorably to that of other health sector investments. Even if the SPA were able to eliminate an extremely conservative 1 percent of Egypt's efficiency gap, the cost per year of life saved would be only \$18.40, which still compares favorably to other health sector investments.

Using the same assumptions as the cost-effectiveness analysis, a benefit-cost analysis was conducted to calculate the potential social benefits of health policy reform. Regression analysis was used to answer the following question: "If Egypt's health sector had attained an average level of efficiency compared to other countries in the sample in 1990, what percent of its GDP would it have had to spend to obtain the same level of average life expectancy as it obtained in that year?" According to the calculations, Egypt would only have had to spend 1.55 percent of its GDP on health in 1990, instead of the 4.7 percent of GDP that it did spend, to achieve the same health outcome. In relation to current levels of GDP, this savings would amount to \$29 per capita, or a total of \$1.74 billion. If, once again, one assumes that the SPA is able to eliminate 10 percent of Egypt's health sector efficiency gap, the social benefits would be about \$2.90 per person, or \$174 million. The analysis further indicates that, assuming the same 10 percent reduction in inefficiency, SPA in the amount of \$75 million would yield a benefit-cost ratio of 11.9 and an internal rate of return of 91 percent over a 15-year time frame.

3.3 Analysis of the Individual Reform Strategies

Analysis of the individual policy reforms proposed by the MOHP and USAID that are expected to be incorporated into the SPA indicates that substantial gains in efficiency can be expected with most components of the health policy reform strategy. For example:

- ▲ Using case-based reimbursement methods to allocate the recurrent budget to hospitals might save as much as \$28 million;
- ▲ Applying cost-effectiveness criteria to the allocation of only 1 percent of Egypt's health spending could save as much as \$12.2 million per year;
- ▲ Reallocating MOHP recurrent expenditures such that their marginal social benefit is equal in each governorate would make it possible to achieve the same level of health outcomes with 3.1 percent less total expenditure, a net savings of \$2.8 million per year; and

- ▲ If steps taken to eliminate the HIO deficit made that system's hospitals as efficient as university hospitals by reducing their expenditures by 53 percent, the expected annual savings would be about \$36 million per year.

In conclusion, Egypt's current macroeconomic environment places increasing pressure on the government to become more efficient. This aspect of the environment should provide impetus for health reform. Other features of the environment, such as the possibility of an impending devaluation, also bear careful monitoring. The fact that Egypt's health sector appears to be highly inefficient creates a unique opportunity to reap substantial economic benefits from health policy reform. The policy reform strategy developed by the MOHP and USAID has the potential to secure a significant share of these anticipated benefits.

4. Social Vulnerability Analysis of the Proposed Health Reform Agenda

The purpose of Volume III in the series, *Social Vulnerability Analysis of the Health Sector Policy Reform Program Assistance in Egypt* (Denise DeRoeck, Heba Nassar, David Hotchkiss, and James Knowles), was to examine the likely impact of the various proposed health policy reform strategies on socially vulnerable groups. An additional objective of the analysis was to identify the steps that should be taken to maximize the positive and minimize the negative effects of policy reform on the socially vulnerable. The term socially vulnerable groups focuses specifically on women and children and is defined to include the poor, residents of disadvantaged rural areas, and female-headed households. The analysis concentrates on four primary effects in the GOE's draft policy reform agenda:

- ▲ introducing cost recovery in MOHP facilities;
- ▲ redirecting MOHP resources from curative to primary health care;
- ▲ reallocating MOHP personnel and other resources from geographic areas of underutilization and excess supply to needy areas; and
- ▲ improving and expanding national health insurance.

The social vulnerability analysis involved conducting primary analysis of the data from the 1994 Health Expenditure Survey to focus on utilization and spending patterns of the poor, women, and female-headed households, as well as secondary analysis of existing documents. The overall conclusion of the social vulnerability analysis is that most aspects of the policy reform would have positive effects on the socially vulnerable. In the case of cost recovery, however, the impact on the socially vulnerable will depend on how it is implemented, as discussed below.

4.1 Introducing Cost Recovery in MOHP Facilities

The analysis indicates that the MOHP health facilities and services are used more heavily by the socially vulnerable than by other population groups. Under these circumstances, charging user fees for MOHP services would have a disproportionately negative effect on the socially vulnerable, either by disproportionately increasing the cost of their health care or disproportionately lowering their utilization of health services (or some combination thereof). However, if suitable mechanisms for identifying and exempting the poor from having to pay user fees (e.g., means testing, geographic targeting) are developed, implemented, and carefully evaluated, the potentially adverse effects of user fees can be minimized.

In addition, if the revenue from user fees is used to improve the quality of care in facilities used by the socially vulnerable (being careful, in the case of hospitals, to ensure that the quality

improvements are focused on actual services used by the socially vulnerable and not those used by physicians' private patients) and to increase the share of MOHP resources used for primary and preventive care, both the economic and health status effects of cost recovery can be strongly positive for the socially vulnerable. Obtaining such positive effects from cost recovery would require that the MOHP gradually reduce its budget allocations to hospitals (at least relatively, if not absolutely) as their user fee revenue expands.

An additional finding of the social vulnerability analysis relative to cost recovery is that the socially vulnerable tend to use MOHP ambulatory facilities rather than hospitals for outpatient services, suggesting that fees could be raised for hospital outpatient services without having significant adverse effects on the socially vulnerable (even in the absence of means testing). When effective MOHP means testing procedures have been implemented and/or social insurance is improved and expanded, user fees for inpatient care can be raised to a level where they recover a substantial share of, if not total, cost. Last, with respect to cost recovery, the analysis emphasizes the need for a strong research and evaluation component to measure the impact of cost recovery on health care utilization and spending of the socially vulnerable as well as to monitor the effectiveness of MOHP's means testing and targeting effects.

4.2 Redirecting MOHP Resources from Curative to Primary Health Care

The social vulnerability analysis also clearly shows that substantial differentials remain in health status, as well as in access to and utilization of primary and preventive health care, between the socially vulnerable and other groups in Egypt. There is no question but that the health status of the socially vulnerable would be much enhanced by policy reforms that succeed in shifting MOHP budget priorities from the current emphasis on urban, hospital-based, technology-intensive curative care to primary and preventive health care, particularly MCH services in rural areas. A redirection of MOHP resources to and increased focus on preventive health services could result in a substantial increase in the use of these services by socially vulnerable populations and ultimately lead to significant improvements in their health status. The MOHP has already demonstrated, through its diarrheal disease control and tetanus toxoid programs, that it can implement preventive health care programs that significantly reduce maternal and child mortality and morbidity in a relatively short period of time, even in remote areas. To maximize the impact of these policy reform strategies, however, the social vulnerability analysis recommends that they be carried out under the following conditions:

- ▲ curative care and PHC services should be offered at the same place and at the same time in order to reduce costs in terms of time and travel;
- ▲ noticeable improvements in quality of curative care services in primary health facilities must be achieved, especially in terms of increases in drugs and equipment, as well as personnel reallocation;
- ▲ continuing education should be offered to staff, including PHC and MCH training to physicians and nurses;
- ▲ health education and promotion activities should accompany efforts to focus on PHC and MCH; and

- ▲ PHC improvements should not be carried out at the expense of curative inpatient care.

4.3 Reallocating MOHP Personnel and Other Resources to Needy Areas

Several reforms focus on redistributing MOHP personnel and other resources from geographic areas of underutilization and excess supply to areas where unmet needs are greatest. These areas include rural areas, areas with the lowest health status indicators, and areas that are underserved by the public health system. These reform strategies could go a long way to redress the current health care system's inequities and benefit the socially vulnerable, provided that they focus on the provision of primary health care and other cost-effectiveness services, and that the quality of care in MOHP facilities is simultaneously improved. The personnel reforms which provide incentives to physicians relocating to presently underserved rural areas may, however, adversely affect female physicians and health workers more than their male colleagues because of the harsh conditions under which they would have to live and work.

4.4 Improving and Expanding National Health Insurance

Also established in the analysis was the fact that the current social insurance program (HIO) disproportionately benefits population groups other than the socially vulnerable (i.e., predominantly the urban middle classes) was also established in the analysis. Eliminating the HIO deficit, particularly if the savings accruing to the GOE are used to expand primary and preventive health services, would unambiguously help the socially vulnerable, few of whom are currently HIO members. The expansion of a suitably redesigned and restructured social insurance program oriented to the financing of catastrophic illness (i.e., with greatly reduced benefits for hospital outpatient care and drugs) would also help the socially vulnerable, who currently must either do without needed inpatient care or incur expenditures which result in severe financial hardship.

In addition, implementing several proposed reform strategies, such as developing an appropriate benefits package, establishing premiums and co-payments based on actual costs, and contracting services out and allowing beneficiaries to choose providers, would be necessary before the government would be willing to embark on an ambitious and potentially costly program of universal health insurance. To protect the poor, however, both the HIO and the eventual national health insurance program should include an exemption system or a sliding scale for premiums and co-payments. Such a system might include charging premiums and co-payments above costs for the wealthiest beneficiaries to cross-subsidize the health care of poorer beneficiaries. Alternatively, the health insurance cost for the poor might be subsidized out of general tax revenues.

The strategies that call for separating HIO financing from the provision of health care, which would involve the insurance program contracting with providers and allowing beneficiaries to choose among providers, would potentially benefit the socially vulnerable by improving the quality of care and increasing their utilization of health services. These effects have been demonstrated in Ismailia, where an HIO experiment allowing a portion of beneficiaries to receive outpatient care from the Suez Canal University's group practice resulted in a substantial increase in utilization of outpatient services (Kemprecos, 1993). Given the relative shortages of MOHP and other government facilities in some rural areas, contracting out for services would have to include private providers and facilities as well.

4.5 Further Research Needs and Recommendations

The social vulnerability analysis concludes by identifying a need for continued support of research with newly available data sets (e.g., the 1996 CAPMAS budget survey, the 1995 Demographic and Health Survey [DHS], the 1995 Poverty Study) to sharpen our understanding of the likely impact of health policy reform on the socially vulnerable. It also calls for continued support of research on the demand for health services, particularly on the factors which affect the choice of public versus private providers and on the trade-offs between price and quality in patient demand. Continued research on the cost effectiveness of alternative health interventions in Egypt is also needed to guide MOHP supply and pricing of health services and for use in developing a suitable minimum benefits package for a redesigned social insurance program. The analysis concludes by recommending a study of the net health benefits (subsidies minus taxes) currently received by different income groups from the GOE budget. A better understanding of the system's current redistributive effects would be useful in focusing policy reforms to produce the greatest net gains for the socially vulnerable.

5. Legal Analysis of the Proposed Health Reform Agenda

The origins of the legal framework of state and parastatal organizations that provide health services and social health insurance in Egypt go back to the 1950s, but the present structure was developed during the 1960s when Egypt adopted socialism as a political and economic regime. This contrasts with Egypt's current market economy. It is not, therefore, a surprise that the strategies that the Egyptian health care system adopted in the past are different from those suggested jointly by the MOHP and USAID at present. The analysis reported in Volume IV of PHR's sectoral analyses in Egypt, *Legal Analysis of the Health Sector Policy Reform Program Assistance in Egypt* (law firm of Hassouna & Abou Ali), was designed to:

- ▲ identify possible legal constraints to SPA policies that are likely to be undertaken during the implementation of this project;
- ▲ identify legislative changes or amendments that may be necessary to enact the project in a timely manner; and
- ▲ assess the feasibility of enacting these changes or amendments.

The legal analysis focused on three primary state and parastatal organizations that provide public health services: the MOHP, HIO, and the CCOs. To obtain a universal understanding of the system as a whole, a brief analysis of the legal framework of university hospitals and educational hospitals and institutes was also included. The Information and Decision Support Center (IDSC) was frequently consulted during the study to verify the accuracy of amendments to laws, decrees, and regulations. In examining the legal framework of these organizations and the structure pursuant to which they provide health services, the study focused on examining the feasibility of implementing the following strategies selected from the set of reforms proposed by the MOHP and USAID:

- ▲ **Rationalize the Role of the MOHP in Financing Curative Care**
 - △ Stop the construction of unnecessary hospitals
 - △ Transfer existing hospitals to other organizations
 - △ Expand cost recovery in government facilities
 - △ Allow private practitioners to use the MOHP facilities
 - △ Allow hospital autonomy
 - △ Provide incentives for health care providers in hospitals

- ▲ **Reform Curative Care Organizations**
 - △ Establish new CCOs
 - △ Improve the autonomy of CCOs
- ▲ **Reform the MOHP Personnel Policy**
 - △ Eliminate guaranteed employment
 - △ Develop guidelines for MOHP personnel and apply them to redistribute personnel
 - △ Reduce the overall number of MOHP personnel
- ▲ **Reform the Health Insurance Organization**
 - △ Unify the existing health insurance laws into one law
 - △ Do not add any new groups of beneficiaries to HIO
 - △ Stop constructing new HIO hospitals
 - △ Sell or transfer of HIO hospitals and clinics
 - △ Develop different mechanisms to subcontract all health service providers
 - △ Design and develop a single national health insurance fund for universal coverage

5.1 Existing Legal Constraints to Program Assistance Policies

The study found that no absolute legal constraints to the proposed health policy reforms exist. The issuance of presidential and ministerial decrees, and possibly certain amendments to existing laws, may be necessary, however, to achieve some of the proposed activities. Changes in a law require a parliamentary act. Presidential decrees, tools by which public authorities and organizations such as the HIO are established and regulated, are issued by the president after having consulted with the government. Ministerial decrees are issued by the appropriate minister, and are somewhat easier to obtain.

5.2 Actions Required to Implement Reform Strategies

The final section of the study, summarized in Table 3 below, discusses each of the above strategies suggested by the MOHP and USAID and indicates where a passive action or change in a law, presidential decree, or ministerial decree is or could be required. The time needed to effect any

of the legislative changes to implement the suggested strategies cannot be determined at the outset. This largely depends on the political will behind these changes.

Table 3: Actions Required to Implement Reform Strategies

REFORM CATEGORY	SUGGESTED STRATEGY	LEGAL OR REGULATORY ACTION REQUIRED
Rationalize the Role of the MOHP in Financing Curative Care	Stop the construction of unnecessary hospitals	Passive action
	Transfer existing hospitals to other organizations	<ul style="list-style-type: none"> ▲ To state and parastatal organizations - Presidential decree ▲ To the private sector - law or Ministerial decree ▲ To CCOs - Presidential decree
	Expand cost recovery in government facilities	Amendment to Ministerial Decree 3 and/or a Presidential decree
	Allow private practitioners to use the MOHP facilities	Ministerial decree
	Allow hospital autonomy	Amendment to Presidential Decree 2444 and Ministerial Decree 3
	Provide incentives for health care providers in hospitals	Amendment to Presidential Decree 2444 to grant exemption from Law 47 of 1979
Reform Curative Care Organizations	Establish new CCOs	Presidential decree
	Improve the autonomy of CCOs	Amendment to Law 61 of 1963
Reform the MOHP Personnel Policy	Eliminate guaranteed employment	Passive action (policy determination by the Cabinet of Ministers)
	Develop guidelines for MOHP personnel and apply them to redistribute personnel	Legislative amendment
	Reduce the overall number of MOHP personnel	Amendment to Law 47
Reform the Health Insurance Organization	Unify the existing health insurance laws into one law	Amendment to existing laws
	Do not add any new groups of beneficiaries to HIO	Passive action
	Stop constructing new HIO hospitals	Passive action (by board of directors of the HIO, subject to concurrence of the MOHP)
	Sell or transfer of HIO hospitals and clinics	Law, Presidential decree, or Ministerial decision
	Develop different mechanisms to subcontract all health service providers	No legal constraints (HIO decrees could be needed if a wider scheme is adopted)
	Design and develop a single national health insurance fund for universal coverage	Amendment and overhauling of HIO's Decree 1209, Law 79 of 1975 (particularly Articles 48 and 84), and Law 126 of 1981

6. Political Analysis of the Proposed Health Reform Agenda

Volume V in the series, *Analysis of the Political Environment for Health Policy Reform in Egypt* (Nihal Hafez), analyzed Egypt's political environment in the context of health sector reforms proposed by the MOHP and USAID by examining political trends as well as the perceptions, agendas, and priorities of key health sector players, and their collective impact on the health policy environment. This analysis consisted of five parts:

- ▲ a review of Egyptian political trends that have affected health sector policy;
- ▲ a description of key players and stakeholders and their organizational objectives;
- ▲ an assessment of the international donors' role in Egypt's health sector reform;
- ▲ an analysis of public opinion about the reform; and
- ▲ an analysis of the political feasibility of the proposed health sector reforms.

Information for the analysis was collected from public documents, research papers, and a few telephone interviews. The main findings of the analysis are summarized below.

6.1 Egyptian Political Trends Affecting Health Sector Policy

There is serious concern in Egypt about the nation's health care services. Although there is growing recognition at all levels of society of the need for significant changes, health policy reform to date is not a topic of explicit public debate. The debate focuses on the deteriorating health sector conditions rather than specific health policy changes. Issues such as competing national health objectives and the associated trade-offs are not discussed in government agencies, or academic and intellectual circles.

During the last two decades, Egypt has moved from the concept of a centrally planned socialist model to a more liberalized market-oriented economy. It is the government's intention to gradually allow the private sector to play a bigger role and to pursue and expand its structural and sectoral adjustment programs. The threat of serious resistance from many sections in the society, including fundamentalist groups, political parties, labor unions, and entrenched bureaucracy, coupled with the lack of institutional capacity, however, has caused reforms in the health sector to lag behind reforms in other sectors.

The two most significant policy questions confronting Egypt today revolve around the changing role of the GOE and the future of the social health insurance program. The MOHP has the most power to mobilize policy changes in either of these two domains. International donors propose

reform packages and support them by funding and technical assistance. The National Assembly, as the representative of the Egyptian public, retains the ultimate authority of clearing the policy for execution. Depending on the reform package chosen, a variety of health institutions, such as the HIO, CCO, GOE hospitals, the Medical Syndicate, and/or non-governmental organizations (NGOs), can become critical players during the policy implementation phase. The Supreme Health Council, Shura Council, universities, intellectual circles, and other advisory bodies are likely to provide input to policy design.

6.2 Key Players and Stakeholders

The GOE, as represented by the MOHP, is the agency most likely—but not necessarily most qualified—to lead any policy reform to be implemented in the Egyptian health sector. The private and non-governmental sectors are not represented in the policy dialogue. The NGOs, however, have the potential of becoming active and effective participants if invited to join the debate. The private and government sectors view each other as adversaries, and this is reflected in the government's attitude towards matters of regulatory nature, and in the private sector's lack of interest in public policy debates. While most of the Egyptians depend on health care through private providers because of the failure of government services, there is a perception in the public mind that the private sector is exploitative and profit-oriented. The consumers of health services in Egypt, however, are not organized and have no way of expressing their views.

Physicians represent the most powerful professional group in the health sector. Those who are employed by the government, but run a private practice on the side because of their low salaries, account for a large portion of private providers. They represent a major interest group and have a significant stake in any major reform. The Medical Syndicate is the physicians' professional association, and presumably the official channel through which their views are expressed. To date, however, the syndicate's role in national policymaking has not been significant.

Though the distinction between the government sector (the MOHP and other ministries) and the parastatal sector (the HIO and CCO) is usually made when describing the Egyptian health sector, both sectors are, in practice, run by the state. From operational and financial perspectives, the parastatals are governed by their own set of rules and regulations, have separate budgets, and exercise more autonomy in daily operations. From a political perspective, however, the GOE/MOHP has a controlling share of decision-making in parastatal organizations, and will accordingly determine their role in the reform process. It is the minister of health and population who appoints or discharges the chairman of the HIO and authorizes any change in the social health insurance policy.

6.3 The Role of International Donors

The role of international agencies in initiating, facilitating, and sustaining public policy reforms in Egypt is significant. While there are many donors working in the health sector, USAID has been by far the most active in the policy area. The World Bank has recently begun a dialogue with the MOHP regarding health sector reforms, as a part of the proposed European Union health sector investment project, with an estimated outlay of US\$120 million.

6.4 Public Opinion

The public perception remains that it is the government's responsibility to provide free health care to all citizens. Even after it became evident that the country's growing health needs have exceeded the government capacity to pay and provide for all, the expectation is for the government to come up with a solution. The discussions in the National Assembly, opposition parties, newspapers, and labor syndicates are more in rhetorical terms rather than addressing the real issues, and are still dominated by a vision of the welfare state.

6.5 Political Feasibility of Egypt's Reform Strategies

The most critical aspect of the analysis was studying the true reform commitments of the GOE, such as how far it is willing to go with the change, how it intends to go about it, and at what pace. The incumbent minister of health and population has expressed his views on health sectoral reform, both before and after his appointment. These views, coupled with the knowledge gained from the past performance of health sector reform endeavors (e.g., the Cost Recovery for Health Project [CRHP]), and combined with an evaluation of the current political conditions in Egypt, lead us to believe that the most politically feasible health sector reforms are the following:

6.5.1 Rationalization of the Role of the MOHP in Curative Care

Rationalization of the role of the MOHP in curative care can be achieved by dedicating more resources to cost-effective health interventions, primary and preventive care, and underserved and rural areas. The actual termination of the provision of curative care by the MOHP, or the transfer of its hospitals to a parastatal or NGO, are not likely to be supported in the short run, however. Also, the government's true commitment to stopping new hospital construction remains questionable.

6.5.2 Expansion of Health Sector Resources

Increasing the health sector's share in the gross national product (GNP), imposing health-earmarked taxes, enhancing partnerships with private and non-governmental sectors, and encouraging community health financing are likely options. Also, cost-containment policies, like rationalizing drug consumption, minimizing government waste, and limiting growth of the labor force, have high acceptance within the government. Though "economic treatment" schemes have been adopted in many MOHP facilities, however, nationwide expansion of cost-recovery systems is not the MOHP leadership's preferred policy. Even in the event of supporting the use of fee-for-service systems on a large scale, the government will authorize charging only modest or "minimal" fees that fall well short of recovering full service costs. Moreover, the government still pledges its commitment to support, at least in theory, vulnerable populations and is not likely to eliminate subsidies for these populations until an alternative social protection mechanism is already in place.

6.5.3 Changes in Manpower Policy

Plans to review and modify medical education and training programs and to promote health management and health economics expertise have wide support. Although the minister of health and population is open to a review of employment and compensation policies, and supports taking measures to limit further growth of the governmental labor force, the termination of guaranteed government employment is not likely to be undertaken in the foreseeable future.

6.5.4 New Roles for the MOHP

Development of the role of the MOHP in national policy making and sectoral planning and in regulation, accreditation, and quality assurance has wide acceptance inside and outside GOE circles.

6.5.5 Health Systems Development and Management Improvements

The development of health information systems, management training programs, cost controls, and effective referral systems as means to improve the technical efficiency of the health sector are all favored interventions among all stakeholders. Also, coordination and integration between health, population, and environmental agencies, between the MOHP and other involved ministries, and between the governmental and private sectors are some of the mandates of the incumbent minister of health and population.

6.5.6 Ensuring the Viability of HIO and Expanding Insurance Coverage

Both the MOHP and HIO support: (1) the review of health insurance regulatory framework and unification of legislation; (2) the review and subsequent modification of the current benefits package; (3) separation of financing and provision; (4) HIO institutional development; (5) quality of care improvements; (6) reduction of waste and control of drug consumption; and, (7) promotion of a bigger role for private sector health insurance. The GOE, however, is likely to exert political pressure to further expand HIO beneficiaries and ultimately achieve universal coverage. HIO itself, however, tends to be skeptical about expansions that are too accelerated, not carefully planned, or beyond the organization's administrative or financial capabilities.

6.6 Conclusions and Recommendations

Some of the above findings do raise concerns about the political feasibility of a tangible health care reform—depending on the specific elements of a reform package, how the reform process is managed, and other factors in the broad political environment. The political analysis suggests the following preliminary actions to improve the political feasibility of health sector reforms:

- ▲ involve all major stakeholders in policymaking and implementation;

- ▲ emphasize national ownership of reforms;
- ▲ focus on politically feasible reforms versus those that require significant restructuring of the health sector;
- ▲ involve physicians in the reform process and examine the political conditions under which the Medical Syndicate would likely promote or obstruct health sector reforms; and,
- ▲ manage the politics of reform by conducting a political mapping exercise that can provide problem identification, policy formulation assistance, and implementation strategy suggestions.

In conclusion, the assessment of the political environment illustrates that both opportunities and obstacles abound. The current political timing represents a window of opportunity for Egypt: significant foreign aid is ready to be committed to support the reform, the political conditions have relatively stabilized, and other sectoral reforms have demonstrated their success. Although the GOE is likely to continue to avoid controversial policies or hard decisions that are likely to provoke public resistance or political antagonism, there is room to move forward with health sector reforms and policy changes deemed “politically safe” that can improve the overall performance of the health sector and alleviate its current distortions and inequities, thus preparing the groundwork for more aggressive structural changes.

7. Institutional Analysis of the Proposed Health Reform Agenda

Volume VI, *Analysis of the Institutional Capacity for Health Policy Reform in Egypt* (Nihal Hafez), is an institutional analysis of the health sector players most critical to Egypt. The study was designed to:

- ▲ assess the competence of each organization in performing its current role to determine whether these roles should be expanded, sustained, or limited under the reforms;
- ▲ assess each organization's potential capability to readily undertake its proposed new role under the reforms; and
- ▲ identify some of the changes needed to enhance the reforms' feasibility, prosperity, and sustainability.

Internal reports and external audits were used to complete the analysis. Due to the scarcity of information available from these documents, however, a framework for institutional assessment was also developed, which provides methodologies and a comprehensive set of organizational indicators that can be used to produce a more detailed analysis.

Although there are tremendous institutional problems confronting Egyptian health care organizations, the future of health sector reform appears positive and its implementation should be encouraged. In fact, the diversity and intensity of the existing problems are ideal for a sector-level approach to reform. In addition, reforms will likely redefine the roles of health sector organizations, and this redefinition may, in itself, solve many of the institutional deficiencies, with little need for further intervention.

7.1 Analysis of Major Health Sector Organizations: Current and Potential Roles in Health Reform

Currently, the two most significant health policy questions facing Egypt revolve around restructuring: (1) the current role of the government in health care; and, (2) the future role of the national health insurance program. The institutional capacity of the MOHP and the HIO will thus be critical success factors for any health sector reform likely in Egypt. Other institutions that can affect the reform, but to a lesser extent, include related government ministries, other parastatal organizations, advisory councils and committees, professional syndicates, and international donor organizations. This institutional analysis, which assessed strengths and weaknesses in the structure, functioning, and culture of these organizations, indicated the following:

7.1.1 Ministry of Health and Population

The MOHP has several institutional deficiencies, including: a fragmented structure that lacks the institutional framework for performing strategic roles in sectoral analysis, policy making, regulation, and accreditation; underdeveloped management and information systems; and a highly centralized authority structure. The ministry and its affiliated facilities are overstaffed and often misallocated. There is a strong recognition of the need for reform, yet political will for certain key reform strategies is lacking. The MOHP's strengths, however, include some successful programs, and an eager and well-trained staff who, if targeted, mobilized, and effectively led, can become catalysts for change.

7.1.2 Health Insurance Organization

The HIO suffers from the lack of an institutionalized structure to undertake policy development and strategic planning; absence of a middle management tier; and lack of autonomy to set premium rates, define benefits packages, contract services, and set up co-payments for services. The HIO has no institutional capacity to implement cost controls or set standards for management and monitoring of its many branches. The nascent managed care structure of the HIO and its growing mandate to provide health care to a larger portion of the population, however, can clearly play an important role in health sector reform. Compared to the CCO or MOHP, which do not finance health care, the financing features of the HIO give the organization potentially great economic power to act as a vehicle for reform.

7.1.3 Curative Care Organization

The CCO is not run as an integrated provider organization, but operates as a loose confederation of hospitals without a centralized corporate management structure or any centrally administered efforts to manage utilization and control costs, and improve quality throughout all member hospitals. The location of CCO facilities tends to be highly concentrated, limiting its potential for growth into a nation-wide system. If a transfer of ownership of MOHP hospitals is proposed as part of the reform, the CCO will need to increase its institutional capacity to be able to run these hospitals effectively.

7.1.4 Other Government Ministries

Other government ministries that play a role in health sector policymaking in Egypt include the ministries of Planning, Finance, and Local Administration, which are involved in planning, budgeting, and resource allocation. The MOHP, though officially the national health policy making agency, has little control over health care financing and budgetary discretion. The ministries of Planning and Finance do not have the technical expertise to determine health sector priorities and needs, and their inter-ministerial budget allocation process allocates funds to government units based on the claims made by each of these agencies separately, without consideration of overall health sector priorities.

7.1.5 Health Sector Advisory Bodies

Health sector advisory bodies including the health committees of the National Assembly, Shura Council and Supreme Council for Health, lack either the technical capacity to analyze policy options, or the legislative power to authorize them, or both. Their roles, accountabilities and relationships to each other and to other health sector players are not well defined. Their structure and composition undermine their potential for effectively setting national priorities for health care.

7.1.6 International Donors

The role of international donors in initiating and promoting health sector reform in Egypt is significant. USAID has been by far the most active in the policy area. USAID has previously supported the Egyptian government through projects complementary to the health sector reform process, and is currently assessing the feasibility of a health sector SPA. The World Bank, which, to date, did not have significant health sector activity in Egypt, recently initiated health policy discussions with the minister, and may get involved in a proposed European Union health sector investment project. Both USAID and the World Bank encourage restructuring roles of major health sector players; separating finance, management, and service delivery; improving the sector's allocative and technical efficiency; developing the MOHP and HIO's institutional capacities; and reforming health manpower policy.

7.2 Recommendations to Increase Institutional Capacity

The analysis identified the following institutional changes that are needed to enhance the feasibility, prosperity, and sustainability of health sector reform in Egypt:

- ▲ The minister and senior MOHP staff should state the reform agenda themselves, commit to it, and set up an institutional framework (e.g., a Health Policy Unit) within the ministry to coordinate policy development and implementation tasks. It is also important that the reforms be prioritized and that agreement on the common minimum agenda rather than a whole menu of broad range reforms be reached.
- ▲ The policy analysis/development and sectoral planning roles of the key health sector institutions, especially the MOHP and HIO, must be strengthened through organizational development, capacity building, and technical assistance.
- ▲ The MOHP must define its current roles as a national health policy and development agency, regulatory agency, and service delivery agency. The HIO must define its roles as a financing, management, and/or provider organization.
- ▲ Both the MOHP and HIO must undertake organizational analysis and restructuring to become more decentralized, promote middle management responsibility, and clearly delineate organizational levels.
- ▲ The MOHP should have more control over health care financing and budget allocation. The role of other ministries should be one of coordination and integration.

- ▲ The HIO should be granted more autonomy to expand population coverage, set premium rates, define benefits packages, contract services, and set up co-payments, in a manner consistent with its financial viability.
- ▲ The HIO could benefit from improvements in its dealings with providers, especially in utilization management/review, quality control, and contracts monitoring.
- ▲ The roles of the various agencies, committees, task forces, and advisory bodies involved in health sector policymaking and their interrelationships must be clearly defined to avoid overlaps and conflicting reform priorities. International donor efforts should be similarly coordinated.
- ▲ The design of donor health policy support programs should be sensitive to the key factor that constrains the sector's ability to move forward in policy reform, namely, the current absence of an institutional capacity to analyze alternative policies.

The analysis concludes by emphasizing that the magnitude of institutional problems facing Egyptian health care organizations should not discourage health sector reform initiatives. In fact, it is the very diversity and intensity of the problems that make the “sectoral-level” approach to reform mandatory. An attempt to correct all structural, functional, and cultural deficiencies identified by this analysis through “organizational-level” interventions, approaching each individual institution in isolation, is not likely to be feasible or affordable in an Egyptian context. Sectoral reforms are likely to redefine the roles and accountabilities of the various health sector players, and then modify health policies and organizational conditions accordingly. Often, the redefinition can in itself treat many of the underlying institutional deficiencies, with little or no need for further intervention.

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